STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065376	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Greenwood Village	6450 S Boston St Greenwood Village, CO 80111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to offer choices to residents for two (#1 and #23) of three residents reviewed for activities of daily living (ADL) out of 35 sample residents. Specifically, the facility failed to: -Ensure Resident #1 and #23 received showers consistently according to their choice of frequency. Findings include: I. Record review The 3rd floor shower schedule was obtained from certified nurse aide (CNA) #3 on 3/28/24 at 1:22 p.m. It documented odd numbered rooms' residents were to receive showers on day shift and even numbered rooms' residents were to receive showers on the night shift. It documented specific days each room number would be showered. According to the shower schedule, Resident #1's room was to receive showers on Tuesdays and Fridays and Resident #23's room was to receive showers on Wednesdays and Saturdays. II. Resident #1 A. Resident Status Resident #1, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included multiple sclerosis (MS), respiratory failure and neuromuscular dysfunction of the bladder (bladder unable to be controlled by the resident). According to the 3/15/24 minimum data set (MDS) assessment Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The assessment documented the resident was dependent on staff assistance for bathing. B. Resident Interview (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was interviewed on 3/25/24 at 4:20 p.m. Resident #1 said she did not have a choice of when she bathed. Resident #1 said that she had to take her bed bath when it was offered to her or it would not be done. Resident #1 pointed to a sign in her room that said her bath days were on Tuesday and Friday in the morning, which was selected by the facility. Resident #1 said if her bath was not completed it was not re-offered to her. III. Resident #23 A. Resident Status Resident #23, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included heart failure, respiratory failure, cataracts and arthritis. According to the 3/7/24 MDS assessment Resident #23 was cognitively intact with a BIMS score of 13 out of 15. The assessment documented the resident was dependent on staff assistance for bathing. B. Resident Interview Resident #23 was interviewed on 3/26/24 at 9:18 a.m. Resident #23 said her shower days were assigned to her. Resident #23 said if she did not accept her shower at the assigned time she would not get a shower. Resident #23 said she felt she didn't have any choice about how she would prefer to shower and it was dependent on staff workload instead of her preferences. Resident #23 said that she was not comfortable with the current shower assignments. IV. Staff interviews CNA #2 was interviewed on 3/27/24 at 2:31 p.m. CNA #2 said bathing was assigned to residents. CNA #2 said if one resident preferred a different bath day nursing staff would have to switch another resident's schedule to try to accommodate the resident's request. CNA #3 was interviewed on 3/28/24 at 10:40 a.m. CNA #3 said residents did not choose when they received a shower and their showers were scheduled upon admission based on which room the residents were admitted to. CNA #3 said the shower schedule was arranged by room number so staff could get everyone's showers done appropriately. CNA #3 said the shower schedule was determined by the facility and resident rooms were assigned specific days and times for bathing. The director of nursing (DON) was interviewed on 3/28/24 at 11:15 a.m. The DON said residents got choices for when they bathed. The DON said the shower assignment sheet was a guideline to help ensure nursing staff completed bathing for residents and residents could choose other days to shower if they wished. -However, based on resident and staff interviews, residents' shower days and times were assigned to residents according to their room numbers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observation, record review and interviews the facility failed to provide the necessary services to maintain personal hygiene for two (#49 and #23) of four residents reviewed for services to maintain highest practicable quality of life out of 35 sample residents. Specifically, the facility failed to: -Ensure Resident #49 received assistance for nail care; and, -Ensure Resident #23 received assistance to maintain oral hygiene. Findings include: I. Facility policy and procedure The Oral Health Care and Dental services policy, dated November 2017, was received from the director of nursing (DON) on 3/28/24 at 5:41 p.m. It documented in pertinent part, Nursing associates will conduct oral health assessments on admission and at least quarterly to assure that each resident receives adequate oral hygiene. -The nail care policy was requested but was not received by the end of the survey. II. Resident #49 A. Resident status Resident #49, age 77, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included alcohol abuse and adult failure to thrive. The 2/6/24 minimum data assessment (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required partial to moderate assistance with all activities of daily living (ADL). B. Observations On 3/25/24 at 11:12 a.m., Resident #49's fingernails were observed to be long and discolored. Resident #49's fingernails were visibly soiled and had a dark substance under several nails. On 3/28/24 at 5:16 p.m., Resident #49's fingernails continued to be long and visibly soiled. A dark substance was still present under several nails. C. Resident interview (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #49 was interviewed on 3/25/24 at 2:07 p.m. Resident #49 said he tried to trim his own nails but had difficulty doing so. Resident ##49 said the facility staff had not offered to trim his nails. D. Record review The comprehensive care plan, initiated on 12/1/23 and revised on 12/12/23, revealed Resident #49 had an ADL self care performance deficit. Pertinent interventions included checking nail length, trimming and cleaning nails on bath day and as necessary and notifying nursing staff of any changes. The comprehensive care plan further revealed Resident #49 had potential for impairment to skin integrity. Pertinent interventions included keeping the resident's fingernails short. The 1/10/24 progress note from the social services director (SSD) revealed Resident #49 needed nail care and the certified nurse aide (CNA) and nurse on staff were notified. The 1/31/24 skin evaluation revealed Resident #49 had long fingernails and had multiple scratches on his legs. E. Staff interviews CNA #2 was interviewed on 3/27/24 at 2:31 p.m. CNA #2 said CNAs at the facility trimmed residents' nails whenever they needed them to be trimmed. CNA #2 said the residents were due for a nail trim whenever the nails started to look longer but some residents declined having their nails trimmed. CNA #3 was interviewed on 3/28/24 at 2:27 p.m. CNA #3 said CNAs could cut the fingernails of nondiabetic residents whenever they saw they were long. LPN #5 was interviewed on 3/28/24 at 5:16 p.m. LPN #5 said Resident #49's fingernails looked bad and they needed to be trimmed. LPN #5 said Resident #49's fingernails did not look clean and were too overgrown. 50314 IV. Resident #23 A. Resident status Resident #23, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included heart failure, respiratory failure, cataracts and arthritis. According to the 3/7/24 MDS assessment, Resident #23 was cognitively intact with a BIMS score of 13 out of 15. The assessment documented the resident required substantial or maximum assistance with oral hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #23 was interviewed on 3/26/24 at 9:18 a.m. Resident #23 said she needed help with setting up her oral care supplies and she did not always get assistance with that Resident #23 said staff helped her brush her teeth now and then but it was often forgotten. Resident #23 said she hated how her teeth felt when they were not brushed and said she felt forgotten. C. Record review -Review of the comprehensive care plan, initiated 3/11/24, failed to document Resident #23's oral care assistance needs. -Review of the CNA tasks in Resident #23's electronic medical record (EMR) revealed the resident was to receive oral hygiene assistance, however, there was no documentation to indicate Resident #23 had received the assistance she needed. D. Staff interviews CNA #4 was interviewed on 3/28/24 at 9:15 a.m. CNA #4 said she was unable to locate oral care documentation for Resident #23. CNA #4 said Resident #23 required set-up assistance with oral care. LPN #6 was interviewed on 3/28/24 at 9:19 a.m. LPN #6 said she could not find oral care documentation for Resident #23. LPN #6 said Resident #23 required one person assistance with oral care. The DON was interviewed on 3/28/24 at 9:31 a.m. The DON said there was no oral care documentation for Resident #23. The DON said Resident #23's oral care documentation did not include the proper question to document oral care properly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to ensure two (#47 and #16) of three residents out of 35 sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, the failed to: -Assess and document Resident #47's blood pressure and heart rate consistently prior to administering blood pressure medications; and, -Obtain weights according to the physician's orders for Resident #16. Findings include: I. Resident #47 A. Professional reference According to Khashayar, F., [NAME], J. (2022). Beta Blockers. Stat Pearls. National Library of Medicine, retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK532906 on 4/1/24. Beta receptors are found all over the body and induce a broad range of physiologic effects. The blockage of these receptors with beta-blocker medications can lead to many adverse effects. Bradycardia (low heart rate) and hypotension (low blood pressure) are two adverse effects that may commonly occur. The patient's heart rate and blood pressure require monitoring while using beta-blockers. According to Kizior, R. J., [NAME], K. J. (2023). Metoprolol. [NAME] Nursing Drug Handbook. Elsevier, p. 770. Assess B/P (blood pressure), heart rate immediately before drug administration. If pulse is 60 beats per minute or less or systolic B/P (upper number) is less than 90 mmHg (millimeters of mercury) withhold medication and contact physician. B. Resident status Resident #47, age 70, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included type two diabetes mellitus, hypertension (high blood pressure) and heart disease. The 3/6/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required set-up assistance for eating, oral hygiene and personal hygiene. He required supervision assistance with toileting and showering. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The March 2024 CPO documented a physician order of Metoprolol Tartrate Oral Tablet 25 mg (milligrams), give 25 mg by mouth every 12 hours related to essential hypertension, hold for SBP (systolic blood pressure) <110 (less than) or HR (heart rate) <55, ordered 2/28/24. The February 2024 and March 2024 vital signs summary revealed Resident #47 blood pressure and heart rate were not assessed for the morning dose of Metoprolol on Resident #47's blood pressure and heart rate were not assessed prior to the administration of Metoprolol on 3/11, 3/14, 3/16, 3/17 and 3/23/24. Review of the medication administration record (MAR) revealed the Metoprolol was held for the morning dose of Metoprolol on 3/18/24 due to the resident's vitals not being within parameters. -However, there was no documentation in the resident's medical record that indicated the resident's blood pressure and heart rate were assessed prior to the medication being held. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/27/24 at 4:04 p.m. LPN #1 said blood pressure and pulse should be taken prior to administering blood pressure medications. LPN #1 said most physician orders for blood pressure medications had parameters indicating when to hold the medication. LPN #1 said when administering a blood pressure medication the electronic charting system typically prompted the nurse to document the resident's blood pressure and pulse prior to administering the medications. LPN #1 said Resident #47's order for Metoprolol was not imputed correctly into the electronic charting system and was not alerting the nurses to document the resident pulse and blood pressure. The director of nursing (DON) was interviewed on 3/28/24 at 9:58 a.m. The DON said she recently implemented having the physician orders for blood pressure medications requiring the blood pressure and pulse to be taken and documented on the MAR prior to administration of the medication. The DON said if the vital signs were not documented in the resident's medical record she assumed they were not completed. The DON was interviewed again on 3/28/24 at 12:39 p.m. The DON said she followed up with the licensed nurse who held Resident #47's Metoprolol on 3/18/24 due to the resident's vitals not being within the parameters in the physician's order. The DON said the licensed nurse recalled seeing the vital signs documented by a certified nurse aide (CNA) on a piece of paper. The DON said she was unable to locate the piece of paper that had the documented vital signs. The DON said she would begin immediate education to the CNAs on the importance of documenting vital signs and ensuring blood pressure and pulse were taken prior to the administration of blood pressure medications. 48112 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident #16 A. Facility policy and procedure The Weight and Height policy, was received by the registered dietitian on 3/28/24 at 4:07 p.m. It read in pertinent part: Residents should be weighed upon admission/re-admission, weekly for three weeks, and as needed. Residents will be weighed on admission/readmission and then weekly for three weeks, monthly or as needed thereafter. For 2 pound weight variance, conduct re-weigh as needed for accuracy. Notify the charge nurse of weight variances as indicated. B. Resident status Resident #16, [AGE] years old, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included hemiplegia and hemiparesis (paralyzed and and weakness) following cerebral infarction (disruption in blood flow) affecting right dominant side, diabetes mellitus type two, seizures, heart failure, cardiac pacemaker and muscle weakness. The 2/13/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. She required substantial assistance with oral hygiene and personal hygiene. She was dependent with toileting, showering, dressing. She had no behaviors or rejections of care. C. Record review The nutrition care plan, revised 2/14/24, revealed the resident was at nutritional risk as evidence by varied meal intakes and weight loss. Interventions included monitor weights as ordered. The February and March 2024 medication administration record (MAR) was reviewed. It revealed the following orders: -Weight on admission and repeat weekly for three weeks every day shift for weight monitoring. Start 2/14/24. -The resident refused on 2/6/24 and 2/21/24. -The 2/14/24 weight was 134.8 pounds. -The MAR documented not applicable for 2/28/24. -There was no documentation that the provider or registered dietitian (RD) was notified that the weights were not obtained. Resident #16's weight history revealed the following: -On 2/7/24, the resident weighed 134.8 pounds; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/14/24, the resident weight 134.8 pounds; and -On 3/1/24, the resident weighed 129.8 pounds. -There was no reweigh documented with the weight change of more than two lbs from 2/14/24 to 3/1/24. D. Staff interviews The DON was interviewed on 3/28/24 at 12:44 p.m. She said if a resident refused to be weighed, the staff should attempt to weigh the resident the next day. The RD should be notified. The registered dietitian (RD) was interviewed on 3/28/24 at 2:32 p.m. She said there would be weekly weights ordered at time of admission for most residents because of the resident's comorbidities like congestive heart failure and diabetes. If there was a discrepancy, she would ask the certified nurse aide (CNA) to re-weigh the resident and check to see if the scale malfunctioned. She said if a resident refused a weight, the staff should attempt again within 24 hours. She said the provider and she should be notified during morning meetings. She said weights were important because it helped give a better understanding of the resident's health. The RD said Resident #16 was at the facility over six months ago. She had c-difficile (a germ that causes diarrhea). She lost weight from her previous admission so that was a trigger for weight loss. She said she had the order for weekly weights in the first month.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review, and interviews the facility failed to ensure two (#49 and #16) of four residents reviewed for ancillary services out of 35 sample residents received proper foot care and treatment according to standards of practice. Specifically, the facility failed to ensure foot care was provided for Resident #49 and Resident #16. Findings include: I. Facility policy and procedure The foot care policy was requested on 3/28/24 at 6:01p.m. however it was not received. II. Resident #49 A. Resident status Resident #49, age 77, was admitted to the facility on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included alcohol abuse and adult failure to thrive. The 2/6/24 minimum data assessment (MDS) assessment showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required partial to moderate assistance with all activities of daily living. -The CPO did not reveal any diagnoses of diabetes or other comorbidities. B. Resident interview Resident #49 was interviewed on 3/25/24 at 2:07 p.m. Resident #49 said he tried to trim his own nails but had difficulty doing so. Resident #49 said the facility staff had not offered to trim his nails and his toenails were significantly worse than his fingernails. C. Observations On 3/27/24 at 3:40 p.m. licensed practical nurse (LPN) #4 removed Resident #49's socks. Resident #49's toenails were several millimeters thick, discolored and growing at different angles. One of Resident #49's toenails had grown out and curved completely over the end of the resident's toe pad. D. Record review The 12/1/23 care plan, revised on 12/12/23, revealed Resident #49 had an activities of daily living self care performance deficit. Pertinent interventions included checking nail length, trimming and cleaning nails on bath day and as necessary and notifying nursing staff of any changes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/10/24 progress note from the social services director (SSD) revealed Resident #49 needed nail care and the certified nursing aide (CNA) and nurse on staff were notified. The 2/2/24 physician notes indicated Resident #49 had thick, yellow toenails were several centimeters thick on both feet. Resident #49 had a fungal infection on his feet and the left great toe and severe onychomycosis (a fungal infection affecting nails). The 2/14/24 physician notes indicated Resident #49 had continued severe onychomycosis of his toenails. There was concern that a topical regiment may not have been effective in treating the infection and Resident #49 declined an oral medication regimen. A podiatry evaluation for Resident #49 was pending. The 2/28/24 physician notes indicated Resident #49 had continued severe onychomycosis of his toenails. Resident #49 declined an oral medication regimen and a topical regimen would not suffice. A podiatry services sheet revealed Resident #49 had been signed up for podiatry services on 1/18/24. -However, he was not provided services (see interview below) on 1/18/24 and there was no documentation on why he did not receive services. -No additional podiatry consults for Resident #49 were revealed. E. Staff interviews CNA #2 was interviewed on 3/27/24 at 2:31 p.m. CNA #2 said the CNAs at the facility trimmed residents' nails whenever they needed them to be trimmed. CNA #2 said the residents were due for a nail trim whenever the nails started to look longer but some residents declined having their nails trimmed. CNA #2 said the facility's podiatrist came once a month to provide services and trim diabetic residents' nails. LPN #4 was interviewed on 3/27/24 at 3:57 p.m. LPN #4 said he reviewed the podiatry consult list and saw that Resident #49 refused podiatry services on 1/18/24. LPN #4 said he was not sure if Resident #49 had podiatry services offered since that time but had not seen anything indicating the resident had been offered additional podiatry services. The director of nursing (DON) was interviewed on 3/27/24 at 4:22 p.m. The DON, upon examining Resident #49's toenails, said his toenails needed to be seen by the facility's podiatrist. The DON said she would get Resident #49 seen by the podiatrist very soon. The DON said residents' need for ancillary services was identified by the physician, nurse or the resident's family. The DON said assessments for ancillary services were done at least annually. CNA #3 was interviewed on 3/28/24 at 2:27 p.m. CNA #3 said that CNAs could cut the finger and toenails of nondiabetic residents whenever they saw they were long. CNA #3 said she tried not to cut residents' toenails because she was worried about causing ingrown nails. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS coordinator (MDSC) #2 was interviewed on 3/28/24 at 2:26 p.m. MDSC #2 said residents' need for ancillary services was identified during daily care by the nursing staff and added to the ancillary service log. MDSC #2 said this was the same procedure for podiatry services. LPN #5 was interviewed on 3/28/24 at 5:16 p.m. LPN #5 said Resident #49's nails needed to be trimmed. LPN #5 said Resident #49's nails did not look clean and were too overgrown. LPN #5 said Resident #49's nails needed to be taken care of by the facility podiatrist. LPN #5 said the facility podiatrist came every month to provide services to the residents. 48112 III. Resident #16 A. Resident status Resident #16, [AGE] years old, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included hemiplegia and hemiparesis (paralysis and and weakness) following cerebral infarction (disruption in blood flow) affecting right dominant side, diabetes mellitus type two, seizures, heart failure, cardiac pacemaker and muscle weakness. The 2/13/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. She required substantial assistance with oral hygiene and personal hygiene. She was dependent with toileting, showering, dressing. She had no behaviors or rejections of care. B. Resident interview and observations Resident #16 was interviewed on 3/25/24 at 2:48 p.m. She said she loved to have someone trim her toe nails, specifically her left big toe nail. Her left big toe nail was long, approximately one half an inch longer than her toe. Resident #16 was interviewed on 3/28/24 at 9:25 a.m. She said she wanted her toenails to be looked at. Her left big toe nail was the same length as observed on 3/25/24. C. Record review The diabetes mellitus care plan, revised 2/14/24, revealed an intervention was to refer Resident #16 to a podiatrist or foot care nurse to monitor and document foot care needs and to cut long nails. The ADL self care performance deficit care plan, revised 2/19/24, revealed the CNA to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. -The resident's electronic medical record (EMR) did not reveal that Resident #16's nail care was addressed by nursing and social services department or by the resident's Kardex (tool utilized by staff to help provide consistent care for residents). (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interview LPN #7 was interviewed on 3/28/24 at 9:27 a.m. She said nurses were responsible for nail care. Nail care was documented as a nurse note in the resident's EMR. She was not aware that Resident #16's left toenail was long. The DON was interviewed on 3/28/24 at 11:22 a.m. She said a podiatrist came every 62 days for toe nail care. She said nurses were responsible for nail care for residents who were diabetic and CNAs were responsible for nail care for residents who were not diabetic. She said if the CNA was responsible for nail care their task documentation informed them who needed nail care. She was not aware Resident #16's left toenail was long and she said she would schedule the podiatrist to see the resident the next time the podiatrist made a visit. She said the podiatrist was scheduled in the next couple of days.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for two (#6 and #41) of three residents out of 35 residents Specifically, the facility failed to ensure Resident #6 and Resident #41, who were both at risk for falls, had their beds in the lowest position when the residents were in bed. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E. [NAME], St. Louis Missouri, pp. 2016, retrieved on 4/1/24, Patient safety is your priority, so although you should raise the bed for a comfortable working level, be sure to place the resident's bed in the lowest position before leaving the bedside. II. Facility policy The Falls Management policy was obtained from the director of nursing (DON) on 3/27/24 at 5:41 p.m. It documented in pertinent part, Residents have the potential to fall and therefore the facility has identified universal fall precautions for all residents which include an admission fall risk evaluation. The Falling Star Program policy was obtained from the DON on 3/27/24 at 5:41 p.m. It documented in pertinent part, A resident will be referred to the falling star program if they are identified as being at risk for falls or if the resident has suffered two or more falls. Referral to the falling star program includes placing a yellow star on the door of the identified resident and additional care planning for fall prevention. III. Resident #6 A. Resident status Resident #6, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included chronic kidney disease, gout and hypothyroidism. According to the 2/18/24 minimum data set (MDS) assessment, Resident #6 had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident required dependent care for bathing, toileting, and dressing. The resident required substantial assistance with oral hygiene and moderate assistance with eating. B. Observations and interview (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 was observed to have a yellow star on their door throughout the survey, which indicated the resident was a member of the Falling Stars Program (see policy above). On 3/25/24 at 2:06 p.m., Resident #6 was lying in bed with the bed in a high position. No staff were present in the room with the resident. On 3/26/24 at 1:00 p.m., Resident #6 was lying in bed with the bed in a high position. No staff were present in the room with the resident. On 3/27/24 at 8:41 a.m., Resident #6 was lying in bed with the bed in a high position. No staff were present in the room with the resident. On 3/27/24 at 4:07 p.m., Resident #6 was lying in bed with the bed in a high position. The DON said the resident's bed was not in the lowest position as it should be when the resident was in bed. She said Resident #6 had been identified as a fall risk and was a member of the Falling Star Program. The DON entered the resident's room and proceeded to use the bed control to lower the resident's bed to its lowest position, approximately 12 inches off the floor. Record review Review of Resident #6's care plan, revised 12/14/23, identified the resident was at risk for falls. The care plan documented the resident was added to the Falling Star Program on 3/19/24. -The care plan failed to document that the resident's bed should be in the lowest position when the resident was in bed. IV. Resident #41 A. Resident status Resident #41, over the age of 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included depression, generalized anxiety disorder and hypertension (high blood pressure). According to the 3/20/24 MDS assessment, Resident #41 had moderate cognitive impairment with a BIMS score of 10 out of 15. The resident was dependent on care for his toileting and bathing needs, and required substantial assistance with eating, personal hygiene and dressing. B. Observations Resident #41 was observed to have a yellow star on their door throughout the survey, which indicated the resident was a member of the Falling Star Program. On 3/25/24 at 2:25 p.m., Resident #41 was lying in bed with the bed in a high position. No staff were present in the room with the resident. The resident was yelling into the hallway that he needed help getting out of bed. On 3/26/24 at 4:00 p.m., Resident #41 was lying in bed with the bed in a high position. No staff were present in the room. The bed was approximately three feet above the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 8:22 a.m., Resident #41 was lying in bed with the bed in a high position. No staff were present in the room with the resident. Record review Review of Resident #41's care plan, revised 3/14/24, revealed the resident was at risk for falls. The resident was identified as a member of the Falling Stars Program and an intervention to provide the resident a safe environment was documented. -The care plan failed to document that the resident's bed should be in the lowest position when the resident was in bed. V. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 3/27/24 at 3:32 p.m. LPN #2 said beds in the facility were able to be lowered to about 12 inches off the floor. LPN #2 said a low bed position must be included in the resident's plan of care for nursing staff to put beds in a low position. LPN #2 said it was not required for resident beds to be in the lowest position and it was up to nursing judgment to determine what the safest bed position was for the resident. The DON was interviewed on 3/27/24 at 4:07 p.m. The DON said all residents identified as a risk for falls should have their beds in the lowest position when they were in bed. The DON said nursing staff was to follow the facility's protocol, not make their own judgment call, for keeping beds in the lowest position when residents identified as fall risks were in bed to ensure resident safety.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review, interviews and observations, the facility failed to provide an effective pain management regime in a manner consistent with professional standards of practice, resident-centered care plans and resident preferences for one (#216) out of 35 sample residents. Specifically, the facility failed to: -Ensure a pain assessment was completed that identified the onset, the presence and duration of pain for Resident #216; -Ensure to identify the resident's goal for pain management and acceptable level of pain for Resident #216; -Ensure to identify a new pain location for Resident #216; and, -Ensure to monitor the effectiveness of the pain medication for Resident #216. Findings include: I. Facility policy and procedure The Pain Management policy, effective March 2021, was received by the director of nursing (DON) on 3/28/24 at 6:01 p.m. It read in pertinent part: The onset or complaint of unrelieved pain should be documented in the resident record. Interventions for pain management should be documented in the resident's record. The resident's response to pharmacological and non-pharmacological pain management and other interventions should be documented in the resident's electronic chart. The resident's response to pain management interventions should be evaluated for effectiveness. A review of a resident's pain management strategy should be completed during the next evaluation with the resident unless a review is necessitated earlier by a change of condition or ineffective pain management plan. The Pain Management policy, revised October 2022, was received by the DON on 3/28/24 at 6:01 p.m. It read in pertinent part: The program should provide a systematic approach to data collection using objective measurements of the pain level and effectiveness of the pain relief medication. On admission resident should be evaluated for pain. Resident pain causative factors were identified. If the resident is having pain, the level of pain should be measured using a scale of zero to ten, a verbal descriptive scale or PAINAD (a scale used in advanced dementia). Non pharmacological interventions could be appropriate alone or in conjunction with medications. Pharmacological medications may be prescribed to manage pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The healthcare provider and interdisciplinary team (IDT) should establish a treatment regime based on consideration of the resident's current medical condition, history of opiod use disorder, current medication regime, nature, severity and cause of the pain, course of the illness, and treatment goals. New or worsening pain should be identified as a change of condition and should be reviewed by the IDT during the collaborative care review. II. Resident #216 A. Resident status Resident #216, age 86, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), the diagnoses include displaced fracture of lateral malleolus of left fibula, closed fracture, Parkinson's, dementia, hypertension (high blood pressure) and depression. The 3/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview m status (BIMS) score of 13 out of 15. She required supervision with eating, oral hygiene and personal hygiene. She required partial assistance with toileting and bathing. She was on a pain medication regimen and received non-medication interventions for pain. She had pain in the past five days. Her pain rarely occurred and rarely made it difficult to sleep and rarely limited rehabilitation therapy. A numeric scale was not completed for pain intensity. The resident said her pain intensity was described as mild. B. Resident interview and observation The resident was interviewed on 3/26/24 at 9:52 a.m. She said she was in pain. On a scale from zero to ten, she rated her pain as a seven to eight. She said she took oxycodone but it did not help. She said she came from the hospital after she fell at her home. She said she had a compound fracture on her left ankle and three bones were shattered. She said she was in pain and her pain was in her left knee and not her left foot. C. Record review The pain care plan, revised 2/19/24, revealed the resident was at risk to experience pain. Interventions included administer pain medication as ordered, anticipate Resident #216's need to relieve pain, provide pain interventions and follow up for effectiveness of interventions, encourage resident to report pain and monitor, record and report complaints of pain or request for pain intervention. Notify the physician if interventions are unsuccessful or if the current complaint is a significant change from the resident's past pain experience. -The care plan did not identify the location of her pain and non-pharmacological interventions being provided to help alleviate her pain. The 3/12/24 initial pain assessment revealed the resident had a diagnosis which indicated she would be in pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The onset, duration, treatment, location, lifestyle and pain intensity was left blank. -The resident's goal for pain management was not identified. -The care plan and pain assessment did not identify her tolerable pain level. The March 2024 medication administration record (MAR) revealed the following: -Pain observation and non-pharmacological interventions every shift. Non-pharmacological interventions included relaxation techniques, food or fluids, music, change position, adjust room temperature, backrub or message, pet therapy and minimizing noise and light. Start date 3/12/24. -Acetaminophen 500 mg. Take one tablet by mouth every eight hours for pain. Start 3/12/24, discontinue 3/18/24. -Acetaminophen 500 mg. Take one tablet by mouth three times a day for chronic pain related to displaced fracture of lateral malleolus of left fibula. Give at 8:00 a.m. for breakthrough pain before therapy starts. Start 3/18/24. -Oxycodone 5 mg. Take one tablet by mouth three times a day for left ankle surgery. Start 3/13/24, discontinue 3/19/24. -Oxycodone 5 mg. Take one tablet every four hours for left ankle surgery. Start 3/20/24. -Lidoderm patch 5 percent. Apply topically in the evening for pain to left knee. Start 3/27/24 (added during the survey). -Oxycodone 5mg was not administered on 3/20/24 at 12:00 a.m., 3/23/24 at 6:00 p.m. and 3/26/24 at 2:00 p.m. The 3/26/24 nurse progress note documented the medication was on order from the pharmacy. -There was no documentation that the physician was notified. -There was no documentation why the medication was not administered on 3/20/24 and 3/23/24. The resident's pain level prior to acetaminophen 500 mg medication administration revealed the resident's pain level was above five out of 10 eight times out of 26 times the medication was administered. -The resident's pain level was not assessed before or after the administration of acetaminophen from 3/12/24 until 3/18/24. The resident's pain level prior oxycodone 5 mg medication administration revealed the resident's pain level was above five on 20 times out of 42 times the medication from 3/13/24 until 3/19/24. -The resident's pain level was not assessed before or after the administration of oxycodone from 3/13/24 until 3/19/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's electronic medical record did not reveal that the facility followed up to see if the acetaminophen and oxycodone pain medication intervention were effective. The 3/19/24 nurse progress note revealed the resident had complaints of pain distress oxycodone every six hours with no breakthrough. She slept well through the night until she was awaken with pain in her left knee. The 3/20/24 nurse progress note revealed the resident had complaints of pain distress oxycodone was scheduled to change to every four hours with some breakthrough noticed but not by much. She slept much better but with little distress every once in a while. The 3/22/24 nurse progress note revealed the resident complained about pain in her left ankle. The oxycodone 5 mg was administered every four hours and the last dose was at 5:16 a.m. The 3/25/24 nurse progress note revealed the resident had complaints of pain and distress. Oxycodone was changed to every four hours. The resident had some breakthrough when the schedule was kept. The resident was sleeping better but with little distress every once in a while. The 3/27/24 nurse progress note revealed the resident had complaints of pain. The 3/27/24 (during the survey) provider note revealed the resident had knee pain with the use of Oxycodone every four hours. She had breakthrough pain, mostly at her knee and felt it was helping her. She was not interested in reducing the dose frequency. She requested something for knee pain. The pain management plan was tylenol 500 mg every hours, change oxycodone 5 mg to every four hours. The medication helped but not drastically. Lidocaine patch to the left knee due to ongoing complaints of stiffness and soreness. The 3/28/24 provider note revealed the resident's pain management plan was tylenol 500 mg every eight hours and oxycodone 5 mg every four hours. Lidocaine patch to left knee for complaints of stiffness and soreness. Volaren was used in the past but did not help. III. Staff interviews Licensed practical nurse (LPN) #8 was interviewed on 3/28/24 at 9:39 a.m. He said an assessment was completed at time of admission by the admission nurse. The assessment determined if the resident was in pain. If the resident was in pain, the nurse would ask the location of the pain and ask the resident to rate the pain on a scale from zero to ten. Zero on the scale meant the resident did not have pain and ten meant the resident was in the worst pain. He said typical interventions included over the counter pain medications, ice and repositioning. When a pain medication was administered, he asked the resident to rate their pain on a scale from zero to ten. He followed up with the resident 30 minutes to one hour later to see if the medication was effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #8 said Resident #216 was in pain. He said her pain was in her left knee. He said when the resident tried to stand he could hear the bone clicking so he knew the resident had to be in a lot of pain. He said her pain in the past week was in her left knee after she fell . She did not report any pain in her left ankle since she fell . He said one non-pharmacological intervention was to have the resident lay flat and place a pillow under her knee. He reviewed the physician orders for oxycodone and acetaminophen. He did not know why the medication was not updated to reflect that the pain medication was for her knee pain or ankle pain. He said he worked the day shift on 3/23/24. He said the resident was not in any pain between her 2:00 p.m. and 6:00 p.m. scheduled time for oxycodone. He relayed the resident's report to the night nurse. LPN #8 said the night nurse was responsible for documenting why the resident did not get her medication at 6:00 p.m. on 3/23/24. LPN #8 said the facility had an ekit (emergency medication stock) to obtain medications if medication were out of stock. For a controlled medication like oxycodone, he had to call the pharmacy to obtain a verification code before the medication was available. The director of nursing (DON) was interviewed on 3/28/24 at 12:44 p.m. She said a pain assessment was completed at time of admission, five days after admission and every shift. She said the assessment covered the ability for the resident to report pain, if the resident was in pain and if additional assessment was needed. She said pain assessments should be completed every shift. She said the pain assessment should cover the onset, presence, duration, characteristics, cause, location and interventions. She said that the resident's pain management goal should be documented and the assessment did not cover the pain management goal and acceptable level of pain. The DON said if a medication was not administered according to the doctor's order, the nurse needed to notify the physician and family. If the medication was out of stock, the nurse needed to contact the pharmacy to see when the medication would be available. She said the facility had an ekit that included narcotics. She was not working the days Resident #216 did not receive her oxycodone 5 mg. The DON said Resident #216 had post surgical left knee pain. She said the nurse knew to evaluate the effectiveness because the electronic medical record would alert the nurse to check 30 minutes after administration. Resident #216's chart was reviewed with the DON and she did not know why the alert for nurses to document effectiveness did not work for Resident #216. She was not working the days Resident #216 did not receive her oxycodone 5 mg. She said a pain assessment should have been done once the knee pain was identified. She said it was done verbally but there was not an assessment in the resident's record.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46022 Based on observations, record review staff interviews, the facility failed to ensure staffing information was posted in a prominent place, readily accessible to residents and visitors. Specifically, the facility failed to post the total number of actual hours worked by the licensed and unlicensed staff directly responsible for resident care per shift. Findings include: I. Failure to have staffing posted Observations in the facility on 3/26/24 at 4:01 p.m. revealed no nurse staff posting. On the third floor there was a binder that said staffing information. The binder said for only facility staff and agency staff were able to open the binder. The director of nursing (DON) was interviewed on 3/28/24 at 10:07 a.m. The DON said the staffing was typically posted at the nurses station or on a board near the nurses station. The DON said the nursing schedule was in a binder located behind the nurses station on the second floor unit. The DON said the nursing schedule was in a binder at the nurses station on the third floor unit. The DON said she was unsure why there was a sign on the staffing binder that said for facility and agency staff only. The DON said the nursing staffing schedule was not posted in the building where residents and visitors were able to view it. The DON said she would ensure the nursing staffing was posted daily for visitors and residents to read. II. Facility follow up On 3/28/24 at 10:15 a.m. the DON indicated staffing information was posted on the second and third floor units in a visible area.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#265) of four residents reviewed for medication errors out of 35 sample residents. Specifically, the facility failed to follow physician ordered parameters for medication administration for Resident #265's midodrine (a medication used to treat low blood pressure). Findings include: I. Manufacturer's guidelines The midodrine hydrochloride manufacturer's guidelines, dated July 9th 2020, were obtained from the National Institute of Health (NIH) Library of Medicine database on 3/29/24. It documented in pertinent part: Warnings: Supine hypertension (elevated blood pressure when lying down): The most potentially serious adverse reaction associated with midodrine therapy is marked elevation of supine arterial blood pressure (supine hypertension). II. Facility Policy The Physician/Prescriber Authorization and Communication of Orders to Pharmacy policy, dated 2013, was obtained from the nursing home administrator (NHA) on 3/27/24 at 11:14 a.m. It documented that the facility should not administer medications or biologicals except upon the order of a physician/prescriber lawfully authorized to prescribe for and treat human illnesses. The General Dose Preparation and Medication Administration policy, dated 2013, was obtained from the NHA on 3/27/24 at 11:14 a.m. It documented that facility staff should follow manufacturer medication administration guidelines. III. Resident #265 A. Resident Status Resident #265, over the age of 65, was admitted on [DATE]. According to the March 2024 computerized physician order (CPO), diagnoses included myelodysplastic syndrome (a group of disorders caused by blood cells), orthostatic hypotension (low blood pressure when rising from a lying or seated position) and high cholesterol. According to the 10/4/23 minimum data set (MDS) assessment, Resident #265 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record Review According to the February 2024 CPO, midodrine was ordered to be administered three times a day and the medication was to be held (not administered) if the systolic blood pressure (SBP) was above 120 millimeters of mercury (mmHg). -The February medication administration record (MAR) documented 26 different medication administrations of midodrine where the medication should not have been given to the resident because the resident's blood pressure was greater than the physician ordered SBP parameter. -Three of the 26 incorrectly given medication administrations documented a SBP above 140 mmHg, however, the medication was still administered. IV. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 3/27/24 at 8:37 a.m. LPN #2 said medication orders should always be followed. LPN #2 said it was important to give midodrine according to blood pressure parameters ordered by the physician to make sure the resident's blood pressure did not get too high or too low. The director of nursing (DON) was interviewed on 3/27/24 at 9:12 a.m. The DON said medication orders, including blood pressure parameters, should always be followed. The pharmacist (PH) was interviewed on 3/28/24 at 9:53 a.m. The PH said physician ordered parameters for midodrine should always be followed. The PH said administering the midodrine to a resident with blood pressure above ordered parameters could increase the resident's blood pressure further. The medical director (MD) was interviewed on 3/28/24 at 10:07 a.m. The MD said physician ordered blood pressure parameters for medications should always be followed. The MD said administering midodrine for a systolic blood pressure over 140 mmHg was not acceptable and adverse effects from raising the resident's blood pressure could occur.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored in accordance with professional standards on two of 6 medication carts. Specifically, the facility failed to ensure medication carts were locked appropriately when they were unattended. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 1976, retrieved on 4/1/24, All drugs are secured in designated areas only accessible to nurses. II. Facility Policy The Storage and Expiration of Medications, Biologicals, Syringes, and Needles policy was obtained from the nursing home administrator (NHA) on 3/27/24 at 11:14 a.m. It read in pertinent part, The facility should ensure that only authorized facility staff should have possession of keys, access cards, electronic codes, or combinations which open medication storage areas. The facility should ensure that all medications and biologicals are securely stored in a locked cabinet or cart that is inaccessible to residents and visitors. III. Observations On 3/25/24 at 4:56 p.m., the medication cart in the middle hallway of the third floor was left unlocked. Keys were inserted in the medication cart lock, which was in the unlocked position, and the keys were dangling from the lock. There was not a nurse visible near the medication cart. At 5:03 p.m., keys remained in the medication cart in the unlocked position. Licensed practical nurse (LPN) #2 said the keys were his. He took the medication keys, locked the medication cart and removed the keys from the lock. On 3/26/24, during a continuous observation beginning at 10:24 a.m. and ending at 10:29 a.m., the medication cart in the left hallway of the third floor was observed in the unlocked position. There was not a nurse visible near the medication cart. At 10:29 a.m., LPN #3 returned to the medication cart and locked it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff Interviews LPN #2 was interviewed at 5:03 p.m. on 3/25/24. LPN# 2 said medication carts should be locked at all times and keys should never be left in medication carts. LPN #2 said the keys hanging from the unlocked medication cart was a mistake on his part. The director of nursing (DON) was interviewed on 3/27/24 at 9:12 a.m. The DON said medication carts should be locked properly at all times and nurses should have the medication cart keys in their possession at all times. The DON was interviewed again on 3/29/24 at 4:14 p.m. The DON said she was working to implement a plan to ensure medication cart keys were not left in medication carts in the future.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observation, interview and record review, the facility failed to ensure residents maintained adequate hydration for two (#31 and #266) of two residents reviewed for hydration out of 35 sample residents. Specifically, the facility failed to: -Encourage fluid intake for Resident #31; and, -Provide thickened liquids per physician's orders for Resident #31 and Resident #266. Findings include: I. Facility policy The Thickened Liquids policy, revised May 2020, was received from the director of nursing (DON) on 3/28/24 at 6:01p.m. It reads in pertinent part: The purpose of this policy is to provide appropriate food and fluid for residents with health care provider diet orders for thickened liquids to provide adequate hydration and to diminish risk of aspiration. (Charge nurse roles and responsibilities include) collaborate with the Registered Dietician (RD) as needed and communicate diet restrictions to Certified Nursing Assistants (CNA). The Resident Hydration and Prevention of Dehydration policy, revised October 2017, was received from the director of nursing (DON) on 3/28/24 at 6:01 p.m. It reads in pertinent part: The dietician will assess all residents for hydration as part of the comprehensive assessment, at least quarterly, and more often as necessary per resident need. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical record. Aides will report intake of less than 1200 milliliters per day to nursing staff. If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. II. Resident #31 A. Resident status Resident #31, age 88, was admitted to the facility on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included dementia and adult failure to thrive. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/6/24 minimum data assessment (MDS) assessment showed the resident had significant cognitive impairment. The resident required substantial maximum assistance with eating and drinking and was dependant with most other activities of daily living. B. Resident representative interview The resident's representative was interviewed on 3/27/24 at approximately 2:00 p.m. The resident's representative said Resident #31 had intravenous (IV) fluid since the physician said she needed fluid. She said the resident should have her glass next to her so she can drink when she wants. C. Observations On 3/27/24 at 3:11 p.m. Resident #31 had a full glass of thickened orange juice in a Kennedy cup on her bed tray. The tray was pushed away from the end of Resident #31's bed and was not within reach for the resident. At 4:06 p.m. there were three quart-sized bottles of nectar thick apple juice in a bin of ice in Resident #31's room. -However, the resident was supposed to have honey thick liquids (see below). On 3/28/24 at 11:05 a.m. Resident #31 had a full glass of water and juice in a Kennedy cup on her bed tray. The tray was pushed away from the end of Resident #31's bed and was not within reach for the resident. D. Record review The 9/27/22 care plan, revised 2/21/24, revealed Resident #31 was at nutritional risk resulting from being on hospice care and requiring honey thickened liquids. Pertinent interventions included providing extra fluids with each food tray, including four to six ounces of orange juice or other juices twice a day. A dietary evaluation note on 3/4/24 at 4:04 p.m. revealed Resident #31 consumed approximately 50% of all meals and some feeding assistance was noted. Resident #31 was to receive Magic Cup (nutritional supplement) and 120 milliliters of Med Pass (nutritional supplment)four times daily. -No fluid intake parameters were established in this assessment. A progress note on 3/24/24 at 3:48 p.m. revealed a doctor ordered 1000 milliliters of 0.9% saline to be administered IV. The doctor did this in order to treat Resident #31 for suspected dehydration. Further orders from the physician included encouraging fluids and continuing to provide a regular diet with honey thick liquids for Resident #31. A comprehensive nursing assessment from 3/24/24 at 11:04 p.m. revealed Resident #31 received peripheral IV fluids for dehydration. -There were additional measures to ensure the resident received additional oral fluids with her risk of dehydration. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Snack/fluid intake from 2/28/24 to 3/28/24 revealed Resident #31 was offered snacks or fluids 57 times. Of these 57 instances, it was charted that Resident #31 consumed 0-25% of what was offered in 37 of these instances. -There were no indications in the record to determine if Resident #31 was offered a snack, fluids, or both for each instance. -Record review did not reveal any areas in the electronic medical record that specifically recorded fluid intake. E. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 3/27/24 at 3:11 p.m. CNA #2 said Resident #31 drank coffee, orange juice and water but the resident did not like many liquids. CNA #2 said Resident #31 drank nectar thick liquids and said the orange juice Resident #31 had on her bed tray was nectar thick. -However, the resident was ordered honey thick liquids. Licensed practical nurse (LPN) #4 was interviewed on 3/27/24 at 3:40 p.m. LPN #4 said Resident #31 was ordered to receive honey thick liquids. LPN #4 was not sure what the difference between honey and nectar thick liquids but said he would speak with the registered dietitian (RD) to clarify. LPN #4 said the bottles of nectar thick apple juice in the resident's room belonged to Resident #31 and he would clarify with the RD if Resident #31 could drink them. LPN #4 said the bottles of apple juice were not correct and he was going to change them. LPN #4 said that thicker liquids were easier to swallow and that if a resident received the wrong consistency they could cough or aspirate. The director of nursing (DON) was interviewed on 3/27/24 at 4:23 p.m. The DON said it was important for residents to receive the correct consistency of liquid because it could become an aspiration risk. The DON said she was not sure where fluid intake was recorded in the electronic medical record. LPN #5 was interviewed on 3/28/24 at 11:29 a.m. LPN #5 said Resident #31 usually received nectar thickened liquids. LPN #5 said she did not know what the difference between nectar and honey thickened liquids but said she could ask the RD. The RD was interviewed on 3/28/24 at 2:31 p.m. The RD said she was not sure when the nursing staff received their last training on altered liquid consistencies. The RD said residents who received thickened liquids could be at a higher risk of experiencing dehydration and that their fluid intake should be tracked. The RD said there was a difference between honey and nectar thickened liquids, nectar was thinner than honey thick liquid. The RD said that if a resident received the wrong consistency of liquid, they could be at a higher risk of aspiration. The RD said she was not made aware of Resident #31's episode of suspected dehydration. The RD said she would want to know about any episodes of dehydration so she could monitor the resident's fluid intake. The RD said Resident #31's last assessment of fluid intake needs was done during her last quarterly dietary assessment but the RD wanted to reassess her to see what her fluid needs were since the episode. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The primary care physician (PCP) was interviewed on 3/28/24 at 4:08 p.m. The PCP said Resident #31's fluid intake should have been monitored after her episode of dehydration. The PCP said Resident #31 had an episode of dehydration prior to the most recent episode but did not elaborate on this. III. Resident #266 A. Resident status Resident #266, age 88, was admitted to the facility on [DATE]. According to the March 2024 CPO, diagnoses included dysphagia (swallowing difficulty), mild cognitive impairment and metabolic encephalopathy (a change in mental state and function due to chemical imbalances in the blood). The 2/6/24 MDS) assessment showed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required substantial maximum assistance with most activities of daily living and supervision or touching assistance with eating. B. Observation On 3/27/24 at 2:47 p.m. Resident #266 had an Ensure nutritional shake on her bedside table. -The resident was ordered nectar thick liquids (see record review below). At 3:11 p.m. Resident #266 had regular consistency water in her cup at her bedside. C. Record review The 2/20/24 speech language pathologist evaluation revealed Resident #266 had a history of aspiration problems and was a definite risk for aspiration on thin liquids. The evaluation recommended nectar thickened liquids for Resident #266 as a result. The March 2024 CPO revealed Resident #266 required nectar thick liquid consistency. D. Staff interview CNA #2 was interviewed on 3/27/24 at 3:11 p.m. CNA #2 said Resident #266 needed nectar thick liquids. CNA #2 identified that Resident #266 had regular consistency water in her cup and said this was not okay for the resident. CNA #2 was not sure who gave Resident #266 regular consistency water. LPN #4 was interviewed on 3/27/24 at 3:40 p.m. LPN #4 said Resident #266 was ordered to receive nectar thick liquids. LPN #4 said thicker liquids were easier to swallow and if a resident received the wrong consistency they could cough or aspirate.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observations, record review and interviews, the facility failed to provide accessible dining equipment and utensils for residents who need them for three (#22, #18, and #1) of three residents reviewed for adaptive equipment out of 35 sample residents. Specifically, the facility failed to: -Provide adaptive drinking equipment for Resident #22 and Resident #18; and, -Provide plate guards for Resident #1. Findings include: I. Facility policy The Adaptive Equipment policy, revised May 2010, was received from the director of nursing (DON) on 3/28/24 at 6:01 p.m. It read in pertinent part: The Dining Services Management should ensure residents who require adaptive equipment to enhance independence and/or support habilitation during dining will be provided equipment. II. Resident #22 A. Resident status Resident #22, age 89, was admitted to the facility on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included dysphagia and Alzheimer's disease. The 3/5/24 minimum data assessment (MDS) assessment showed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident was dependent for most activities of daily living (ADL) and required substantial maximal assistance with eating. B. Observations On 3/27/24 at 2:26 p.m., Resident #22 had a cup with no lid and handles, a Styrofoam cup, and a soda can with a straw in it on her bedside table. On 3/28/24 at 11:21 a.m., Resident #22 was given a cup of water without handles and with a straw in it by an unidentified facility staff member. At 11:49 a.m., Resident #22 was assisted to the dining room. Resident #22 had a cup without handles and a straw in it on the table in front of her. C. Record review (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan, initiated 8/30/21 and revised 9/1/22, revealed Resident #22 was at nutritional risk due to dysphagia. Pertinent interventions included using a nosey cup (an adaptive cup with a cut out for the resident's nose) for cold liquids and a two handled mug for hot liquids. A dietary meal ticket from 3/28/24 revealed Resident #22 was to be provided with handled cups as available. III. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included dysphagia, parkinsonism, and dementia. The 12/24/23 MDS assessment showed the resident had severe cognitive impairment with a BIMS score of seven out of 15. The resident was dependent with most ADLs and required partial or moderate assistance with eating. B. Observations On 3/27/24 at 5:19 p.m., Resident #18 had two beverages served in glass goblets with a straw in each goblet. On 3/28/24 at 11:48 a.m., Resident #18 was given a soda can with a straw in it. C. Record review The nutrition care plan, initiated 8/15/23, revealed Resident #18 had a nutritional problem due to dysphagia. Pertinent interventions included having occupational therapy screen the resident and provide adaptive equipment for feeding as needed. A dietary meal ticket from 3/28/24 revealed Resident #18 required Kennedy cups (a spill-proof cup that is designed to be used with a straw) as available and a plate guard. IV. Resident #1 A. Resident status Resident #1, age 70, was admitted on [DATE]. According to the March 2024 CPO, diagnoses included multiple sclerosis. The 3/15/24 MDS assessment showed the resident had severe cognitive impairment with a BIMS score of five out of 15. The resident was dependent for most ADLs and required substantial maximal assistance with eating. B. Observation (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/24 at 11:55a.m. Resident #1 was given a plate of food during lunch service without a plate guard on it. C. Record review The nutrition care plan, initiated 11/6/19 and revised 1/10/24, revealed Resident #1 was at risk of nutritional decline due to multiple sclerosis. Pertinent interventions included assisting Resident #1 with meals and liquids as needed. Review of the comprehensive care plan further revealed Resident #1 was at risk for hot liquid injury. Pertinent interventions included cueing and assisting Resident #1 with meals and snacks as needed. -Neither Resident #1's care plan or the March 2024 CPO revealed any interventions put into place for adaptive equipment to assist the resident with eating or drinking. A dietary meal ticket from 3/28/24 revealed Resident #1 required handled cups as available, a plate guard and light-weight built up handles for eating utensils. V. Staff interview The registered dietician (RD) was interviewed on 3/28/24 at 2:31 p.m. The RD said staff members in the therapy and the dietary divisions provided accessible devices such as plate guards. The RD said dietary and nursing staff were both responsible for making sure residents got the equipment they needed during dining service. The RD said the facility was running low on Kennedy cups and they had done the best they could. In lieu of Kennedy cups, the RD said the facility had been putting plastic wrap over the mouth of cups served to residents with a straw through the plastic wrap and using coffee mugs with handles on them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20287 48112 Based on observations, interviews and record review the facility failed to store, prepare, distribute and serve food in a sanitary manner in two satellite kitchens. Specifically, the facility failed to: -Ensure food was labeled and dated and disposed of timely; and -Ensure ready to eat foods were handled appropriately. Findings include: I. Food was labeled and dated and disposed of timely A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 4/9//24 from:https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified in (b) of this section; or Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the Department upon request. B. Observations On 3/27/24 at 11:23 a.m. the refrigerator in the satellite kitchen on the second floor was observed. There was one opened carton of soy milk with an expiration date of 1/21/24. The manufacturer label said the milk stayed fresh for seven to ten days after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no date when the carton was opened. There were two opened Hormel thick and Easy Clear thickener drinks plastic cartons. There was no date when the cartons were opened. The manufacturer label said to discard if not used within 10 days. The cartons were reviewed with the dietary manager (DM) and he discard the soy milk and thickener cartons in the trash. C. Staff interview The registered dietitian (RD) was interviewed on 3/28/24 at 2:53 p.m. The RD said opened containers should have an open by and used by date. She said food and beverages should be discarded by the expiration date. The thickener liquid drinks should have an expiration date and the soy milk should have been discarded on or before 1/21/24. II Ready to eat foods A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 4/4/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view Except when washing fruits and vegetables as specified, food employees may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment B. Observations Third floor satellite kitchen On 3/27/24 beginning at 11:28 a.m. the tray line was observed. Dietary aide (DA) #1 began serving the noon meal. DA #1 placed the serving utensils into the pans on the tray line with bare hands. Prior to donning the gloves she failed to perform hand hygiene. DA #1 was observed to leave the tray line to get something from the refrigerator. She began service by touching the handles of the utensils, which were placed into the pans touched by her bare hands. She took hotdog buns out of the bag and separated the bun with her gloved hands and placed the hotdog onto the bun. DA #1 failed to change her gloves throughout the meal service. -At 12:03 p.m. DA #1 began to remove the dinner rolls from the package with the same gloved hands. She did not use utensils or clean gloved hands to remove the ready to eat food. -At 12:26 p.m. she placed her gloved hand over a sandwich and cut the sandwich in half. C. Staff interview (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM was interviewed on 3/28/24 at 4:18 p.m. He said ready to eat foods should have be handled with a utensil or clean gloves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review, observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infections on two of two units. Specifically, the facility failed to: -Ensure housekeeping staff cleaned from cleaner to dirtier areas; -Ensure housekeeping changed gloves and performed hand hygiene between cleaning the bathroom and bedroom; -Provide accurate isolation precaution and appropriate use of personal protective equipment (PPE); -Ensure staff performed hand hygiene; -Ensure residents were offered hand hygiene prior to eating; and, -Follow the water management plan I. Housekeeping failures A. Professional reference According to The Centers for Disease Control (CDC) Environment Cleaning Procedures, (5/4/23), retrieved on 4/9/24 from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#, Proceed From Cleaner To Dirtier Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: -During terminal cleaning, clean low-touch surfaces before high-touch surfaces. -Clean patient areas (patient zones) before patient toilets. -Within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone. -Clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions. B. Observation and interview (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/24 at 9:11 a.m., the housekeeping supervisor (HSKS) was cleaning room [ROOM NUMBER]. She donned gloves before entering the room. She swept the floor and returned the broom to the cart. She took the cleaning supply caddy from the cart. She sprayed disinfectant on the toilet seat, the exterior of the toilet, the grab bars and the sink in the bathroom. She took a dry cloth and sprayed disinfectant on the cloth. She proceeded to clean the dresser, nightstand and phone in the resident's room. She returned to the bathroom and wiped down the toilet seat, the exterior of the toilet, the grab bars and the sink of the bathroom. Without changing her gloves, she returned the cleaning supply caddy to the cart. She used a clean mop head, which she attached to the mop handle with the same gloves she had been wearing throughout the cleaning of the entire room, to mop the bedroom area and then replaced the mop head before cleaning the bathroom. After mopping the bathroom, the HSKS exited the room, removed her gloves and performed hand hygiene. -The HSKS failed to clean the bathroom from a cleaner area to a dirtier area when she wiped the toilet before wiping the sink. -The HSKS failed to change her gloves and perform hand hygiene after wiping the toilet and before wiping the sink. -The HSKS again failed to change her gloves and perform hand hygiene after cleaning the bathroom and before picking up the cleaning caddy, returning it to the cart and grabbing a clean mop head. C. Staff interview The HSKS was interviewed on 3/27/24 at 9:38 a.m. The HSKS said she changed gloves and performed hand hygiene only between resident's rooms. She said she received training from the facility's infection preventionist (IP). The IP was interviewed on 3/28/24 at 3:05 p.m. The IP said housekeeping should perform hand hygiene and change gloves between cleaning the residents' bathroom and the bedroom. The IP said it was important to perform hand hygiene and change gloves because it prevented the potential spread of bacteria or viruses. II. Isolation precautions/PPE failures A. Professional references According to the Centers for Disease Control and Prevention (CDC) Recommended Routine Infection Prevention and Control (IPC) Practices During the COVID-19 pandemic (revised 7/2024), retrieved on 4/9/24 from https://www.cdc.gov/infectioncontrol/pdf/guidelines/Isolation-guidelines-H.pdf, If they (N95 masks) are used during the care of patients for which a NIOSH (National Institute for Occupational Safety and Health) Approved respirator or facemask is indicated for personal protective equipment (PPE), they should be removed and discarded after the patient care encounter and a new one should be donned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Place a patient with suspected or confirmed SARS-CoV-2 (COVID-19) infection in a single-person room. The door should be kept closed. HCP (Health Care Personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (goggles or a face shield that covers the front and sides of the face). According to the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings (revised 11/29/22), retrieved on 4/9/24 from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html, Remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded after leaving the patient room or care area and closing the door. Ensure that healthcare personnel have immediate access to and are trained and able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others. B. Observations On 3/25/24 at 11:51a.m., room [ROOM NUMBER], which was a COVID-19 positive resident's room, was observed. An unidentified certified nurse aide (CNA) donned a gown, gloves and eye protection. -The CNA put a surgical mask on, but failed to don a N95 mask. She said she was ready to go into the room to serve the meal. The CNA she said she did not know she needed to put the N95 on when she was just passing a tray. On 3/26/24 at 9:17 a.m., room [ROOM NUMBER] was observed again. Two unidentified staff members prepared to enter the room. Both staff members donned a gown, gloves and eye protection. One staff member removed her surgical mask and placed an N95 before entering the room. -The other unidentified staff member had a surgical mask on and placed a N95 mask over the surgical mask before entering the room. C. Staff interviews The IP was interviewed on 3/28/24 at 3:05 p.m. The IP said staff should put on a N95 mask prior to entering a COVID-19 positive room. The IP said if staff were wearing a surgical mask they should remove the surgical mask prior to donning a N95 mask. III. Hand hygiene failures A. Professional reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDC Hand Hygiene in Healthcare Settings (1/30/2020), retrieved on 4/9/24 from https://www.cdc.gov/handhygiene/providers/guideline.html, included the following recommendations, in pertinent part for hand hygiene, Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 4/4/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped singled service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after caring for or handing service animals or aquatic animals, after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; when switching between working with raw food and working with ready-to-eat food; before donning gloves to initiate a task that involves working with food; and, after engaging in other activities that contaminate the hands. B. Observations On 3/25/24 at 11:51 a.m., CNA #5 delivered a meal tray to a resident in room [ROOM NUMBER]. -CNA #5 failed to offer hand hygiene to the resident prior to the meal being served. -At 11:53 a.m., CNA #5 delivered a meal tray to the resident in room [ROOM NUMBER]. -CNA #5 failed to offer hand hygiene to the resident prior to the meal being served. On 3/25/24, during a continuous observation of the third floor dining room beginning at 11:44 a.m. and ending at 12:20 p.m., staff was delivering lunch meals to residents seated at the tables. -None of the residents in the dining room were offered hand hygiene prior to being served their lunch. On 3/27/24 at 11:45 a.m., the dining services supervisor (DSS) grabbed and adjusted a resident's wheelchair wheel. The DSS proceeded to rearrange Resident #18's silverware. -The DSS failed to perform hand hygiene after touching the resident's wheelchair and before touching Resident #18's silverware. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/24, during a continuous observation of the third floor dining room beginning at 11:33 a.m. and ending at 12:37 p.m., staff was delivering lunch meals to residents seated at the tables. -None of the residents in the dining room were offered hand hygiene prior to being served their lunch. C. Interviews The dietary manager (DM) was interviewed on 3/28/24 at 4:18 p.m. He said the DSS should have performed hand hygiene after she adjusted the wheelchair wheel before touching Resident #18's silverware. The IP and director of nursing (DON) were interviewed on 3/28/24 at 3:05 p.m. The IP said handwashing should be offered to residents before and after meals, after using the bathroom and when they got dressed in the morning. The DON said hand wipes were previously used before meals and she did not know when hand wipes stopped being offered to residents. IV. Water management plan A. Professional reference According to theCDC Legionella (Legionnaires Disease and Pontiac fever) (reviewed 3/25/21), retrieved on 4/9/24 from https://www.cdc.gov/legionella/wmp/toolkit/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flegionella%2Fmaintenance%2Fwmp-toolkit.html and https://www.cdc.gov/legionella/wmp/overview.html, Many buildings need a water management program to reduce the risk for Legionella growing and spreading within their water system and devices. Legionella bacteria are typically found naturally in [NAME] environments, but can become a health concern when they grow and spread in human-made water systems. Legionella can cause a serious type of pneumonia (lung infection) known as Legionnaires disease. Some water systems in buildings have a higher risk for Legionella growth and spread than others. Legionella water management programs are now an industry standard for many buildings in the United States. Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires disease. Legionella bacteria can also cause a less serious illness called Pontiac fever. The key to preventing Legionnaires disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key elements of a Legionella water management program are to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Establish a water management program team -Describe the building water systems using text and flow diagrams -Identify areas where Legionella could grow and spread -Decide where control measures should be applied and how to monitor them -Establish ways to intervene when control limits are not met -Make sure the program is running as designed (verification) and is effective (validation) -Document and communicate all the activities. Principles: In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for Legionella growth - Preventing water stagnation -Ensuring adequate disinfection -Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. A consultant with Legionella-specific environmental expertise may sometimes be helpful in implementing and operating water management programs. According to the CDC Controlling Legionella in Potable Water Systems (reviewed 2/3/21, retrieved on 4/1/24 from https://www.cdc.gov/legionella/wmp/control-toolkit/potable-water-systems.html, Store hot water at temperatures above 140 degrees fahrenheit (F) and ensure hot water in circulation does not fall below 120 degrees F. Recirculate hot water continuously, if possible. Store and circulate cold water at temperatures below the favorable range for Legionella (77 degrees F to 113 degrees F)); Legionella may grow at temperatures as low at 68 degrees F. B. Facility policy The Legionella Water Management Program policy, revised February 2022, was provided by the nursing home administrator (NHA) on 3/27/24 at 3:00 p.m. It read in pertinent part, Our community is committed to the prevention, detection and control of water-borne contaminants including Legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The water management program includes the following elements: an interdisciplinary water management team, the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. A diagram of where control measures are applied. A system to monitor control limits and the effectiveness of control measures. C. Record review The NHA provided the Legionella water management plan on 3/27/24. The water management plan was updated on 3/21/24. The program team listed the director of nursing and nursing home administrator. -The names listed on the plan for the DON and NHA did not match the names of the facility's current DON and NHA. The water system flow diagram was a chart that showed the receiving (the boiler room), the cold water distribution, the heating, the hot water distribution and waste. -The diagram did not include a facility map of where the boiler was located, where the distribution points, heating points and hot water distribution points were located. -The diagram did not state how many hot water distribution points were in the facility. -The water management plan did not include when the cold and hot water systems were last verified and when the due date was for next verification. D. Staff interview The NHA and interim maintenance director (IMD) was interviewed on 3/28/24 at 3:49 p.m. The NHA said the IMD was responsible for reviewing the water management plan. He said the staff that were listed on the previous plan revision had not been at the facility for a while. The IMD said the temperatures were documented in an electronic system. The IMD said the water layout and flow was located in the kitchen, everywhere that there were chemicals, laundry, housekeeping, janitor's closet and nurses stations. There was a main ice maker in the kitchen and each satellite kitchen (two) had an ice machine. The NHA said they would review and update the water management plan to make sure that it was specific to their facility and met the regulations.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for one (#6) of five residents reviewed for immunizations out of 35 sample residents. Specifically, the facility failed to administer the pneumococcal vaccination after consent was provided for Resident #6. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2024, retrieved on 4/4/24, from: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, in pertinent part, Routine vaccination-pneumococcal-For those ages 19 to 64 with an additional risk factor or another indication was: One (1) dose PCV15 (pneumococcal 15-valent conjugate vaccine PCV15 Vaxneuvance) followed by PPSV23 (pneumococcal 23-valent polysaccharide vaccine PPSV23 Pneumovax 23)or one (1) dose PCV20 (pneumococcal 20-valent conjugate vaccine PCV20 Prevnar 20). For those over the age of 65 who meet age requirements and lack documentation of vaccination, or lack evidence of past infection was: One (1) dose PCV15 followed by PPSV23 or one (1) dose PCV20. Special situations: Age 19-[AGE] years with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: One (1) dose PCV15 or one (1) dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. Note: Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus (HIV), Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies. Note: Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF (cerebral spinal fluid) leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies. II. Facility policy and procedure (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Influenza Vaccine policy, revised October 2022, was provided by the director of nursing (DON) on 3/28/24 at 3:11 p.m. It read in pertinent part: Resident or resident representatives should be offered the influenza vaccine annually to encourage and promote the benefits associated with immunization against influenza. Obtain a written order from the health care provider. Obtain a written, informed consent upon admission and annually from the resident or resident representative. III. Resident #6 A. Resident status Resident #6, over the age of [AGE] years, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses include chronic kidney disease, osteoporosis and gout. The 2/18/24 minimum data set revealed the resident did not receive the influenza vaccine in the facility and she was not offered the vaccine. She was not up to date on pneumococcal vaccine and she was offered and declined the vaccine. B. Resident representative interview The resident representative was interviewed on 3/28/24 at 2:00 p.m. The representative said they always wanted the resident to be up to date on all vaccinations. The representative said the decision for the resident to receive the pneumococcal vaccination was made with the resident and for her best interest. C. Record review A review of the resident's electronic medical record on 3/28/24 revealed the resident had not received the pneumococcal vaccination. The 1/4/24 informed consent for pneumococcal revealed the immunization was refused. -However, the form was not signed by the family representative, instead it document do not consent and was signed as verbal. This was contradictory to the resident's representative interview (see above). IV. Staff interview The infection preventionist (IP) and DON were interviewed on 3/28/24 at 3:54 p.m. The IP started working at the facility in January 2024. The IP said the nurse was responsible to offer the immunizations the resident needed. If the resident was not up to date on their vaccines, the nurse would have the resident or resident sign a consent. If the resident was eligible for a vaccine but did not want a vaccine, they would sign the consent. The consent indicated they refused the vaccine. The vaccination consents for Resident #6 were reviewed with the IP and DON. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP and DON said it was not clear who refused the vaccines on the consent. The IP would contact the resident's representative to confirm they wanted Resident #6 to be updated with all vaccines.